Homer	$104
Juneau	$429
Ketchikan	$546
Kodiak	$346
Kotzebue	$522
Nome	$522
Petersburg	$508
Seward	$104
Soldotna	$ 94
Valdez	$167
Wrangell	$508

This subsection takes effect January 1, 1991.

(r) For quality assurance, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the product of the facility's appropriate region's average registered nurse wage rate increased by 28.1 percent, multiplied by 96; that product is then divided by the number of medical assistance patient days during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes time after October 1, 1990. This subsection takes effect October 1, 1990.

(s) For social services, the rate of a long-term care facility calculated in (a) — (g) of this section is adjusted upward by an increment that is the product of 5 multiplied by the number of admissions in the facility's base year, multiplied by a number that is the average social worker wage rate in the appropriate region increased by 28.1 percent, and divided by the number of medical assistance patient days during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(t) For patient's rights, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment of $.05. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year allowable costs used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(u) For admission agreements, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the product of $2,500 divided by the number of medical assistance patient days in the facility's base year. If the facility does not have a July through June fiscal year, the number of medical assistance patient days in the facility's base year used in this calculation is the product of total base year medical assistance patient days divided by 12 months, then multiplied by the number of months remaining in the fiscal year, to accomplish payment of the amount described in this subsection by the end of the fiscal year in progress on July 1, 1991. The adjustment shall apply only to the fiscal year in progress on July 1, 1991. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 5/8/88, Register 106; am 6/19/88, Register 106; am 11/1/88, Register 108; am 2/3/89, Register 109; am 3/25/89, Register 109; am 6/18/89, Register 110; am 9/21/90, Register 116; am 8/28/91, Register 119; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.180

Editor's note: Effective with Register 132, January 1995, the regulations attorney made a technical correction to 7 AAC 43.685(f) by changing the citation from 7 AAC 43.683(b) to 7 AAC 43.683 in two places.

7 AAC 43.687. METHODOLOGY AND CRITERIA FOR ADDITIONAL PAYMENTS AS A DISPROPORTIONATE SHARE HOSPITAL. (a) A hospital providing services to a disproportionate share of low-income patients is eligible for additional Medicaid payments for a facility fiscal year beginning on or after July 1, 1988, based upon the facility qualifying for additional payments as set out in this section.

(b) In order to qualify for additional payments as a disproportionate share hospital, the hospital must meet the following criteria for each qualifying year:

(1) except as provided by (d) of this section, at least two obstetricians with staff privileges at the hospital have agreed to provide obstetric services to Medicaid patients;

(2) the hospital must either have

(A) an Alaska Medicaid inpatient utilization rate at least one standard deviation above the mean of Alaska Medicaid inpatient utilization rates for all hospitals in this state; the Alaska Medicaid inpatient utilization rate is a fraction, expressed as a percentage, of which the numerator is the hospital's number of inpatient days for Medicaid-eligible patients in this state for its qualifying year and the denominator is the total number of the hospital's inpatient days for its qualifying year; or

(B) a low-income utilization rate exceeding 25 percent; the low-income utilization rate is calculated as the sum of

(i) the fraction, expressed as a percentage, of which the numerator is the sum of the total Medicaid hospital revenue paid to the hospital for patient services provided to Medicaid-eligible patients in this state in the hospital's qualifying year and the amount of cash subsidies received directly from governments in this state for patient services provided in this state in the hospital's qualifying year, and the denominator is the total amount of hospital revenue for services, including the amount of cash subsidies specified in this subparagraph for the hospital's qualifying year; and

(ii) the fraction, expressed as a percentage, of which the numerator is the total amount of the hospital's charges for inpatient hospital services attributable to charity care, as defined in the manual described in 7 AAC 43.709, for the hospital's qualifying year, less the portion of any cash subsidies received directly from governments in this state for inpatient hospital services, and the denominator is the total amount of the hospital's charges for inpatient services for the hospital's qualifying year; and

(3) the hospital must have a minimum Medicaid utilization rate (MUR) of one percent; the MUR is the fraction, expressed as a percentage, of which the numerator is the hospital's number of inpatient days attributable to patients who, for those days, were eligible for Medicaid under the state plan, and the denominator is the hospital's total number of inpatient days provided to all patients.

(c) If a hospital qualifies as a disproportionate share hospital under (b)(2)(A) of this section, the hospital may not qualify as a disproportionate share hospital under (b)(2)(B) of this section.

(d) For a hospital located outside of a Metropolitan Statistic Area, as defined by the federal Executive Office of Management and Budget, "obstetrician" for the purposes of (b)(1) of this section includes any physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. Criterion (b)(1) of this section does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, nor to a hospital that did not offer nonemergency obstetric services as of December 22, 1987.

(e) The department will determine charges under this section for inpatient hospital services attributable to charity care in accordance with the manual described in 7 AAC 43.709, except that for a state-owned hospital which does not have a charge structure, the hospital's charges for charity care are equal to the cash subsidies received by the hospital from governments in this state.

(f) The department will determine, as of the qualification date, a hospital's eligibility for additional Medicaid payments under this section for the hospital's qualifying year. A hospital that meets the requirements of (b)(2)(A) or (b)(2)(B) of this section must provide the

names and Medicaid provider numbers of at least two obstetricians who meet the requirements of this section, unless exempted under (d) of this section.

(g) The department will calculate a hospital's payment for each year that the hospital is eligible under this section as follows:

(1) a hospital that qualifies for disproportionate share payment adjustments under (b)(2)(A) of this section must elect between

(A) an adjustment to the hospital's Medicaid payment rate for its first fiscal year beginning after the qualification date of one percent plus the percentage by which the hospital's qualifying year Medicaid inpatient utilization rate exceeds one standard deviation above the mean of Medicaid inpatient utilization rates for all hospitals in the state for their fiscal years ending immediately before the qualification date; or

(B) for a qualifying year ending

(i) before June 1, 1994, an adjustment to the hospital's Medicaid payment rate for its first fiscal year beginning after the qualification date of one percent and a cash payment calculated at 1.37 percent of the hospital's qualifying year cash subsidies from governments in this state for each percentage point that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean of Medicaid inpatient utilization rates for all hospitals in the state for their fiscal years ending immediately before the qualification date;

(ii) on or after June 1, 1994, an adjustment to the hospital's Medicaid payment rate for its first fiscal year beginning after the qualification date of one percent and a cash payment calculated at 1.60 percent of the hospital's qualifying year cash subsidies from governments in this state for each percentage point that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean of Medicaid inpatient utilization rate exceeds one standard deviation above the mean of Medicaid inpatient utilization rates for all hospitals in the state for their fiscal years ending immediately before the qualification date;

(2) A hospital that qualifies for disproportionate share payment adjustments under (b)(2)(B) of this section, but does not qualify for disproportionate share payment adjustments under (b)(2)(A) of this section, must elect between

(A) a disproportionate share payment adjustment to the hospital's Medicaid payment rate of one percent plus the percentage by which the hospital's low-income utilization rate exceeds 25 percent for its second fiscal year beginning after the qualification date; or

(B) for a qualifying year ending

(i) before June 1, 1994, an adjustment to the hospital's Medicaid payment rate of one percent for its second fiscal year beginning after the qualification date, and a cash payment calculated at 1.37 percent of the hospital's cash subsidies from governments in this state for its first fiscal year beginning after the qualification date for each percentage point the hospital's low-income utilization rate for its first fiscal year ending after the qualification date exceeds 25 percent;

(ii) on or after June 1, 1994, an adjustment to the hospital's Medicaid payment rate of one percent for its second fiscal year beginning after the qualification date, and a cash payment calculated at 1.60 percent of the hospital's cash subsidies from governments in this state for its first fiscal year beginning after the qualification date for each percentage point the hospital's low-income utilization rate for its first fiscal year ending after the qualification date exceeds 25 percent;

(3) the disproportionate share payment adjustments made to a hospital's payment rate, not including cash payment adjustments described in (g)(1)(B) and (g)(2)(B) of this section, must be in effect for a period of 12 consecutive months beginning with the first month in the hospital's first fiscal year beginning after the qualification date;

(4) the annual disproportionate share payment adjustment for each qualifying hospital is subject to a limit calculated under this paragraph; for the hospital's qualifying year, the limit is the cost of services provided to Medicaid patients, less the amount paid to the hospital under the non-disproportionate share provisions of the Medicaid state plan, plus the cost of services provided to patients without health insurance or another source of third party payments that applied to services rendered during the qualifying year, less any payments made by those patients without insurance or another source of third party payment for those services; the hospital's cost of services for this calculation is the total allowable operating costs of the hospital as defined in 7 AAC 43.685 and 7 AAC 43.686 divided by the hospital's total adjusted patient days; this result is then multiplied by the total of the hospital's adjusted patient days not covered by insurance or third party payment and Medicaid adjusted patient days; the cost of services does not include amounts that were unreimbursed to the hospital by the patient's health insurance or other source of third party payments because of per diem maximums, coverage limitations, or unpaid patient co-payments or deductibles;

(5) the disproportionate share payment is not subject to the payment limitations in 7 AAC 43.685(d);

(6) the disproportionate share payment is not included for purposes of calculating the hospital's future years' Medicaid payment rates or disproportionate share payments or adjustments; and

(7) a hospital that is eligible to receive an annual disproportionate share payment adjustment under this section will receive an additional disproportionate share payment adjustment to its Medicaid rate, expressed as a percentage, for its first fiscal year beginning after the qualification date if the hospital has qualifying patients during the qualifying year as follows:

(A) a qualifying patient is a Medicaid patient who is under age six at the time of admission and has exceptionally long stays per admission in the qualifying year or exceptionally high costs per admission in the qualifying year; an exceptionally long stay per admission means an admission length that is 150 percent or more of the length of stay of an average admission for the hospital, that is calculated as the hospital's total inpatient days for the qualifying year for all children under six divided by the hospital's total admissions of all children under six for the qualifying year; exceptionally high costs per admission means inpatient costs exceeding 150 percent of the hospital's average inpatient costs, which is calculated as the hospital's total inpatient costs for all children under six in the hospital's qualifying year divided by the hospital's total admissions of all children under six for the hospital's qualifying year; inpatient costs for this calculation are the charges to the qualifying patients under this subparagraph multiplied by the ratio of actual total hospital allowable costs related to patient care to total charges for patient care determined in the hospital's rate setting process for Medicaid under this chapter;

(B) the hospital must submit to the department supporting documentation, which includes a qualifying year log for all children admitted under six, specifying charges, admissions, patient days, payments made for services, dates of service, and also documentation specifying total hospital admissions, charges, patient days, and payments made for services; information provided in this log must be accurate, complete, and in sufficient detail to be capable of verification by the department;

(C) the additional disproportionate share adjustment relating to qualifying patients will be applied to increase the hospital's Medicaid payment rate; the adjustment is a fraction, expressed as a percentage, which is the lesser of:

(i) the hospital's allowable patient care costs in the qualifying year for the services provided to qualifying patients under this subsection divided by the total hospital patient care charges for the qualifying year; or

(ii) the disproportionate share payment amount resulting from the disproportionate share payment selection by the hospi-

tal in (1) or (2) of this subsection divided by the total hospital patient care charges for the qualifying year; the hospital's allowable patient care costs in the qualifying year for the services provided to qualifying patients under this subsection for purposes of this calculation are the charges to qualifying patients multiplied by the ratio of actual total hospital allowable cost related to patient care to total charges for patient care calculated in the hospital rate setting process for Medicaid under this chapter less other payments which have been or are anticipated to be received by the hospital for the qualifying patient's care.

(h) For the purposes of calculating the Alaska Medicaid inpatient utilization rate under (b)(2)(A) of this section and for any payment adjustment under (g)(1) of this section, the hospital's qualifying year is the hospital's fiscal year ending immediately before the qualification date. For the purposes of calculating the low-income utilization rate under (b) (2)(B) of this section and for any payment adjustment under (g)(2) of this section, the hospital's qualifying year is the hospital's fiscal year ending immediately after the qualification date.

(i) For the purposes of calculating whether a hospital qualifies for additional payments as a disproportionate share hospital under (b)(2)(A) of this section and for the purposes of calculating a hospital's payment under (g)(1) of this section, the mean of Medicaid inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of inpatient days for Medicaid-eligible patients for all hospitals in this state for their qualifying year and the denominator is the total number of inpatient days for all hospitals in this state for their qualifying year.

(j) The department will make or prorate disproportionate share payments in the following manner:

(1) the payment made to a hospital in its fiscal year beginning on or after July 1, 1988 is one-third of the amount of the full payment adjustment calculated under this section;

(2) the payment made to a hospital in the fiscal year beginning on or after July 1, 1989 is two-thirds of the full payment adjustment calculated under this section;

(3) the payment made to a hospital in its fiscal year beginning on or after July 1, 1990 is the full payment adjustment calculated under this section;

(4) the payment made to a hospital in its fiscal year beginning on or after July 1, 1995 is the full payment adjustment calculated under this section subject to the limits on those payments provided in this section.

(k) In this section, unless the context otherwise requires,

(1) "hospital" means an acute care hospital, a specialty hospital, or an inpatient psychiatric hospital;

(2) "qualification date" means June 1 of each year;

(3) "adjusted patient days" means patient days calculated as the product of patient days times total charges divided by inpatient charges;

(4) "admission" means admission to a hospital for inpatient care;

(5) "qualifying hospital" means a hospital that qualifies as a disproportionate share hospital under this section. (Eff. 3/16/89, Register 109; am 8/25/89, Register 111; am 8/6/92, Register 123; am 5/11/94, Register 130; am 6/29/95, Register 134)

Authority: AS 47.07.040 AS 47.07.070

ARTICLE 13. MENTAL HEALTH CLINIC SERVICES.

7 AAC 43.725. CONDITIONS FOR PAYMENT. (a) To be eligible for Medicaid reimbursement, a mental health clinic must be a

(1) community mental health clinic, as defined in 7 AAC 43.1990, that meets the requirements of (b) of this section; or

(2) mental health physician clinic, as defined in 7 AAC 43.1990, that meets the requirements of (b) and (c) of this section.

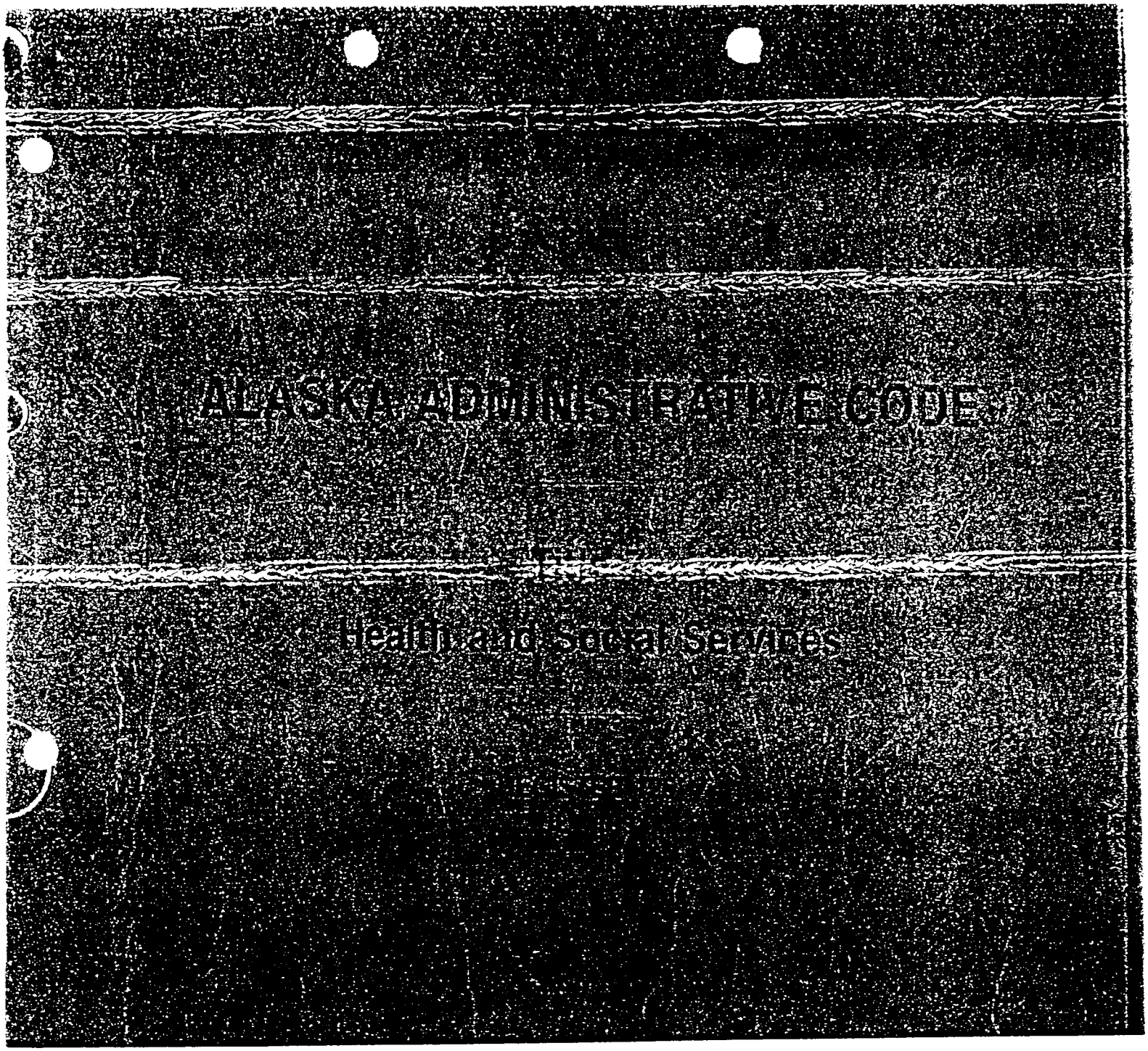
(b) To be eligible for Medicaid reimbursement, a mental health clinic must be administratively, organizationally, financially, and otherwise separate from a health facility, as defined in AS 47.07.900, except that

(1) a governmental or corporate entity may concurrently operate a mental health clinic and a health facility in the same building or in separate locations if

(A) the health facility's administrator and governing board have no administrative or financial authority over the mental health clinic; and

(B) all expenses and income of the mental health clinic are accounted for separately from the expenses and income of the health facility so that the costs of operating the mental health clinic are excluded from the costs considered by the department in determining the health facility's prospective payment rate under 7 AAC 43.670 — 7 AAC 43.709;

(2) a mental health clinic operated by a governmental or corporate entity that concurrently operates a health facility may enter into a written agreement with the health facility under which the health facility is to provide administrative and other support ser-



TN #: 95-06 DATE APPROVED: July 2, 1996
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Article 12. Prospective Payment System

Editor's notes. — 7 AAC 43.675 — 7 AAC 43.705 were repealed by the Department of Health and Social Services in an emergency action effective 6/27/84, Register 91. The Medicaid Rate Commission adopted 7 AAC 43.670 — 7 AAC 43.709 as emergency regulations, effective 6/27/84, Register 91, to replace the repealed regulations.

When the Medicaid Rate Commission emergency regulations were made permanent and amended, effective 10/21/84, Register 92, the substance of the regulations was reorganized and renumbered. The numbering and organization of the material in 7 AAC 43.670 — 7 AAC 43.709, as of 10/21/84, bears no resemblance to the numbering and organization of that material before 10/21/84.

Therefore, the history notes for 7 AAC 43.670 — 7 AAC 43.709 do not reflect the history of those sections before 10/21/84, and references to the emergency repeal of the DHSS regulations on 6/27/84 have been deleted.

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7 AAC 43.670. PURPOSE. The purpose of 7 AAC 43.670 — 7 AAC 43.709 is to implement the provisions of AS 47.07.070 — 47.07.900. (Eff. 10/21/84, Register 92; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.180 AS 47.25.195
AS 47.07.073